

M E M B E R A C C E S S R E Q U E S T

Section A: IPDP Member Requesting Access

Name: _____

Address: _____

City, State, ZIP Code: _____ Phone Number: _____

IPDP ID Number: _____ Social Security Number: _____

☐ Check this box, and complete the information below, if you want your health information records mailed to a different address.

Address: _____

City, State, ZIP Code: _____

Section B: To the member – Please read the following and complete the information requested

You have the right to inspect and obtain a copy of your health information maintained by the Indiana Prescription Drug Program (IPDP). You are not, however, entitled to inspect or copy information used for lawsuits, criminal investigations or prosecutions, notes made by a mental health therapist or psychiatrist, and certain other records. Please complete this form to request access to your health records maintained by the IPDP.

Specify the records, and the dates of the records to be inspected or copied: _____

I want to inspect these records. ☐ I want to obtain copies of these records. ☐

Do you want us to mail the copies? ☐

You may be charged a fee for the costs of copying, mailing, or for other supplies needed to fulfill your request. You will be notified of any costs prior to receiving the requested copies.

If you want us to provide copies of your records to any person other than your or your personal representative, you must provide us with a signed authorization. We can supply you with the appropriate authorization form.

Section C: To the member – Please sign the form and complete the appropriate information

Signature: _____ Date: _____

Section D: To the member's personal representative – Please sign the form and complete the appropriate information

If this request is from a personal representative on behalf of the IPDP member, please provide a copy of the documentation to support the representation and complete the following:

Personal Representative's Name: _____ Date: _____

Relationship to IPDP Member: _____

This form must be notarized if submitted by the member's personal representative.

Subscribed and sworn (affirmed) before me this _____ day of _____, _____

Signature: _____

Notary Public in and for the state of _____

In the county of _____

My commission expires: _____

(Affix seal)

Please mail this completed form to the following address:

State of Indiana
MS07
Indiana Prescription Drug Program
Family and Social Service Administration
402 W. Washington St. Room W386
Indianapolis, IN 46204